



DATE OF REVIEW: 8/29/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the appropriateness of the previously denied request for right lumbar epidural steroid injection (ESI) at L3-4 and L4-5, left cervical ESI at C5-6 **and ESI.**

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas Licensed Orthopedic Surgeon, and is currently listed on the TDI/DWC ADL List.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The previously denied request for right lumbar epidural steroid injection (ESI) at L3-4 and L4-5 and left cervical ESI at C5-6 **and ESI.**

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Fax Cover Sheet dated 8/15/07, 8/9/07, 8/6/07, dated (unspecified).**
- **Authorization Request dated 8/14/07, 6/14/07.**
- **Determination Notification Letter dated 8/9/07.**
- **Notice to CompPartners, INC. of Case Assignment dated 8/9/07.**
- **Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 8/9/07.**
- **Evaluation Report dated 8/7/07.**

- **Confirmation of Receipt of Request for Review by an Independent Review Organization (IRO), 8/6/07.**
- **MRI Lumbar Spine dated 8/3/07.**
- **MRI Cervical Spine dated 8/3/07.**
- **Office Visit dated 7/31/07, 6/21/07, 5/22/07, 4/23/07, 3/20/07, 2/5/07.**
- **Utilization Review Referral Request dated 7/24/07, 6/19/07.**
- **Request Form dated 7/6/07.**
- **Prescription dated 6/26/07.**
- **Supplemental Explanation Report dated 6/26/07.**
- **Letter dated 6/7/06.**
- **MRI dated 1/9/07.**
- **Follow-up Evaluation dated 12/21/06, 7/25/06, 6/22/06, 3/21/06, 1/12/06, 12/13/05, 11/15/05, 9/13/05, 8/26/05.**
- **Post-Operative Orders and Patient Instructions dated 10/27/06, 5/12/06.**
- **Procedure Report dated 10/27/06, 5/12/06.**
- **Operative Report dated 7/10/06.**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Not provided for this review.

Diagnosis:

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The claimant is a male without a specific date of injury or mechanism given. The records did show that the claimant was seeing Dr. for a cervicothoracic and lumbar spine injury. He also was treating with another physician for a shoulder problem. On examination, there was good strength but pain with cervical motion. A cervical injection was recommended as was aquatic therapy. The claimant saw Dr. for pain in the low back into the right leg and right upper extremity pain, although he was reported to be post right shoulder superior labral anterior-posterior (SLAP) repair. There was thoracic spine tenderness. The neurological examination was intact. Lyrica was recommended.

On 03/21/06, the claimant was seen by Dr. It was noted that the claimant had foraminal injections in February 2005 with benefit. The claimant reported aches and pains in the neck and mid back with occasional spasm. The examination was unchanged. The impression was cervical, thoracic and lumbar spondylosis. Dr. felt the claimant had reached maximum medical improvement. Records then showed that the claimant had right L4-5 and L5-S1 facet blocks on 05/12/06, followed by right L3-4, 4-5 and L5-S1 medial branch blocks. Both gave short term relief. On 10/27/06, the claimant had an epidural steroid injection at C5-6. On 12/21/06, Dr. once again saw the claimant for pain in the thoracic region. He noted at that time, that the claimant had undergone facet rhizotomy at L3-4, 4-5 and L5-S1 with good relief. The examination noted pain with motion. Medications were continued and a thoracic epidural steroid injection was recommended.

The claimant had a thoracic MRI on 01/09/07 that showed mild scattered degenerative change without significant disc bulge or herniation and there was no canal stenosis or foraminal narrowing. In 2007, the claimant continued to treat for pain in the thoracic spine, lumbar spine and cervical spine. The examinations noted no neurological deficit. On 03/20/07, epidural steroid injections were again recommended. Injections were recommended on 05/22/07 for the lumbar spine due to increased pain. Examination findings were unchanged. A request was made on 06/14/07, for lumbar and cervical epidural steroid injections.

The 08/03/07 MRI of the lumbar spine, showed multilevel spondylosis. There was moderate canal stenosis at L3-4, a moderate disc bulge, osteophytes, bilateral facet arthritis, moderate canal stenosis and moderate to severe bilateral foraminal narrowing. L4-5 showed moderate disc bulge, bilateral facet arthritis, moderate spinal and foraminal stenosis. L5-S1 was normal. The 08/03/07 MRI of the cervical spine documented C3-4 and 4-5 disc osteophyte and bilateral facet osteoarthritis, bilateral uncovertebral hypertrophy and moderate to severe left foraminal narrowing. At C5-6, there was a disc osteophyte and bilateral facet osteoarthritis, and bilateral uncovertebral hypertrophy with severe foraminal narrowing right more than left. There was a C6-7 disc osteophyte and bilateral facet osteoarthritis, bilateral uncovertebral hypertrophy with moderate bilateral foraminal narrowing.

On 08/07/07, Dr. evaluated the claimant for back and right scapular pain. On examination the gait was mildly antalgic. Strength was 5/5 other than breakaway right deltoid, iliopsoas bilaterally and right dorsiflexors weakness. Negative straight leg raise was documented and sensation was intact. The request for injections has been denied and a dispute resolution was requested.

The reviewer agrees with the denial decision based on the records that were provided for review. This is a male with at least a two-year history of cervical, thoracic and low back pain. The recent MRI scans of the cervical and lumbar spine showed that there are multiple levels of stenosis and foraminal narrowing. Records still do not support the request for epidural injections. There was nothing in the documentation provided, either from Dr. or from Dr., which suggests that the claimant had upper or lower extremity pain in a radicular pattern. There was an absence of electrodiagnostic studies that would support that radiculopathy is present. Records do not document that there are physical examination finding consistent with a neurological deficit such as altered reflexes, decreased sensation or clear motor weakness. The claimant appears to have predominantly axial pain. Injections for axial pain in the absence of radiculopathy are not likely to provide any significant benefit with objective results such as decreased medication use or increased activity. As such, in the absence of radicular pain and findings, the request for epidural steroid injections cannot be recommended.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.
- AHCPR – AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES.
- DWC – DIVISION OF WORKERS’ COMPENSATION POLICIES OR GUIDELINES.

- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN.
- INTERQUAL CRITERIA.
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS.
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES.
- MILLIMAN CARE GUIDELINES.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
 Official Disability Guidelines Treatment in Worker’s Comp 2007 Updates, Cervical and Lumbar Epidural Steroid Injection:

Cervical and Lumbar ESI: 1) Radiculopathy must be documented. Objective findings on examination need to be present to be considered successful after this initial use of block/blocks there should be documentation of at least 50-70% relief of pain from baseline and evidence of improved function for at least six to eight weeks after delivery.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHRIOPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee’s employer, the injured employee’s insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.
